Nottinghamshire Area Prescribing Committee Meeting minutes

APC meeting 17th June 2021, due to the COVID-19 Pandemic the meeting took place as a web conference using Microsoft Teams.

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included, unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present:

Steve May (SM) Chair	Chief Pharmacist	Sherwood Forest Hospitals NHS Foundation Trust
Tanya Behrendt (TB)	Senior Medicines Optimisation Pharmacist	NHS Nottingham & Nottinghamshire CCG
Laura Catt (LC)	Prescribing Interface Advisor	NHS Nottingham & Nottinghamshire CCG
Matt Elswood (ME)	Chief Pharmacist	Nottinghamshire Healthcare NHS Foundation Trust
Tim Hills (TH)	Assistant Head of Pharmacy	Nottingham University Hospitals NHS Trust
David Kellock (DK)	Chair SFH Drug and Therapeutics Committee	Sherwood Forest Hospitals NHS Foundation Trust
Jennifer Moss Langfield (JML)	GP	LMC representative
Sarah Northeast (SN)	Advanced non-medical prescriber	Nottingham CityCare
Asifa Akhtar (AA)	GP – South Notts, ICP	NHS Nottingham & Nottinghamshire CCG
Susan Hume	Advanced non-medical prescriber	Nottinghamshire Healthcare NHS Foundation Trust

Interface support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFH
Shary Walker (SW), Specialist Interface & Formulary Pharmacist for NUH
Hannah Godden (HG), Specialist Mental Health Interface and Efficiencies Pharmacist
Karen Robinson (KR), APC Interface and Formulary Technician

Apologies:
David Wicks (DW), GP – Mid Notts ICP, NHS Nottingham & Nottinghamshire CCG
Khalid Butt (KB), GP – Mid Notts, LMC Representative
Amanda Roberts (AR) - Patient representative
Esther Gladman (EG) GP, City ICP NHS Nottingham & Nottinghamshire CCG

Observing:
Anna Davis, Integrated Care Partnerships Practice Nurse Lead
Ankish Patel, Senior Clinical Pharmacist – Nottingham City GP Alliance
Michalina Ogejo, Medicine Optimation Pharmacist and Pain Pharmacist, PICS

Declarations of interest (DOI)

None declared.

Minutes of the last meeting/matters arising

The minutes from the previous meeting were reviewed and accepted as being accurate

Ibandronic acid for adjuvant treatment of breast cancer
Work is slowly progressing with ibandronic acid now being approved by the cancer board and the business case forwarded to service change cell. Patients are receiving ibandronic acid at NUH, however are now at the point where NUH should have passed over the care.

ACTION: TB and TH to continue to seek resolution

Guideline on the Management of Sleeping Difficulties in Childhood (New)
LC has fed the previous comments from the February APC back to the authors. The final version has not been returned to upload. LC and TH have chased it and TH has escalated to the clinical director for the division. SM has discussed with the author at SFH who believes they are working within the guidelines and are happy to move forward with it.

ACTION: TH will again contact the NUH authors on behalf of the APC, once returned LC will upload the final version.

RMOC Shared Care – a standard approach
Peter Richards (Mid Nott's senior pharmacist) has updated the Private to NHS Prescribing Policy to reflect the discussions that took place at APC around shared care. It will be uploaded once finalised and approved.
LC explained that RMOC were reviewing some medicines that were not already shared care in Nottinghamshire and highlighted that there cannot be an expectation that every item that becomes shared care will be put through the LES for GP payment as that may not be the case. Monitoring for these medicines (e.g. amiodarone) is already done in primary care so changing to shared care is just formalisation rather than moving workload. ME suggested incorporating a grandfather clause to stop the repatriation of all patients to secondary care. JML suggested that all patients should be reviewed to assess the appropriateness of re-referral to secondary care. LC confirmed this work is already being undertaken in primary care for patients on amiodarone.

ACTION: LC to upload Private to NHS Prescribing Guideline once available

Amiodarone Shared Care Protocol
The RMOC consultation on the amiodarone shared care protocol has now closed.The decision has been made to pause work on the local amiodarone shared care protocol and wait for the RMOC version.
IV has been in discussions with secondary care and the following question had been raised around cardiac surgery patients. There is a cohort of patients that are prescribed amiodarone for post-op AF and it is usually only given for 6 weeks or so to ensure patients stay in sinus rhythm. Current practice is for the patient to be given a two week supply from the hospital and then request GP to supply the remainder of the course. They are reviewed in post-op clinic by the surgeon and the decision to continue or stop is made then. It was queried whether amiodarone shared care would be challenging for this group of patients and whether a supply of six weeks from the hospital would be better; therefore making amiodarone RED for this indication. SM and TH were in agreement but noted that patients usually only get two week supply of medicines on discharge; it would have to be ensured that this group of patients are supplied the full course. Suggested the prescribing policy needed to reflect any decision made. The risk of outpatient appointments being delayed was discussed, it was agreed that cardiology would have to prescribe a sufficient supply of amiodarone

to account for this.

ACTION: LC to update IV with the decisions made. IV to bring back the amiodarone SCP once RMOC have published.

Lithium Shared Care Protocol
HG has done some scoping work with other areas with Derbyshire and Leicestershire already having lithium as shared care. HG is going to take her findings to the NHCT medicines optimisation group in July for discussion.

ACTION: HG to bring back the discussion to August APC meeting.

Prescribing Policy
Version 4.1, has been agreed by NUH and SFHT and ME and HG confirmed the agreement from NHCT.

ACTION: LC to upload version 4.1 and highlight to contracting teams to update to this version within the contracts with providers

Post meeting note- the private to NHS prescribing policy is awaiting ratification by the Nottinghamshire Medicines Optimisation Stearing Group and since this sits as an appendix within the prescribing policy, finalisation is slightly delayed.

Vancomycin
TB fed back that oral Vancomycin has been added to the community pharmacy palliative care stock list scheme so certain community pharmacies would hold a supply.

****Other actions were completed or on the agenda for today's meeting****

PCN pharmacist representation

Ankish Patel (AP) of Nottingham City GP Alliance attended to represent the PCN pharmacists. AP and LC asked the APC to consider having PCN pharmacist membership on the committee. Currently, there are over 100 PCN pharmacists and pharmacy technicians across the county. AP felt these were ideally located to take new guidelines forward, cascade and share any updates and implement formulary changes. AP suggested the attendance of 1 of the PCN representatives (North, South and City) on a rolling rota.
The voting rights of PCN representative were discussed and LC suggested the Terms of Reference (ToR) were reviewed and refreshed over the summer to see if changes were required. PCN representation was agreed upon.

ACTION: LC to review the ToR for a future APC meeting.

APC annual report 2021/22

LC presented the APC annual report and gave a brief overview of key points.
The 21/22 report shows a greater cost pressure than savings identified and suggested this was due to a number of decision being made that were cost-neutral.
TB suggested that the APCs input into the Covid response was included as an achievement as the

team had acheived a quick turnaround, posting FAQs on the website and giving valuable resources across Nottinghamshire.
LC informed the group that AR was stepping down from her role as a patient representative. SM felt an official thank you to AR should be mentioned in the report for her tremendous contribution over the years.

ACTION: LC will make the suggested amendments and email the final version for APC approval before submitting

Post meeting note – the cost calculation for cinacalcet has been reviewed and the cost pressure amended to reflect the lower strength which ePACT shows is the strength of choice. The financial impact of APC decisions in 2020/21 now shows a net saving although this is significantly lower than previous years

Antipsychotic prescribing guideline

HG presented the antipsychotic prescribing guideline. HG explained the document was large because it amalgamated together all the current APC information sheets for antipsychotics. Having the antipsychotic information separately had created a lot of repetition and having one guideline now offered a seamless narrative of information which now includes information on first-generation (typical) antipsychotics too. In addition, the guideline also includes new sections based on common queries that the specialist mental health team receive.
Cardiologists from both NUH and SFH have been consulted on the ECG section of the guideline. The guideline has also been reviewed by a consultant psychiatrist in the NHCT early intervention in psychosis service.

The committee felt it was helpful to have all antipsychotic prescribing information in one place.

HG reported on some work in Mid Nott's locality to look at transferring prescribing of depot antipsychotic injections to primary care for patients in specialist care homes. Highlighting that in these cases the nursing staff in the care homes will be carrying out the depot administration rather than GPs. JML highlighted that there should be payment for the administration of depot antipsychotic injections in primary care due to staff time. The committee agreed that it's clinically appropriate to keep depot antipsychotics as Amber 2 and the administration payment aspect is an issue for the CCG. LC and TB can raise this with Rachel Herald at the CCG who looks after the GP LES.

TH asked whether interaction examples should be included in this guidance, as for other APC documents. HG said they had considered this but it was felt that the guideline needed to be as concise as possible and prescribers have the responsibility to check for drug interactions.

The guideline was agreed as ratified.

ACTION: HG to upload the final version to the APC website

Barrier Preparation Formulary

LC presented the updated Barrier Preparation Formulary. A product and prices review had been completed by Emma Moncrieff, MO Pharmacist, Nottingham and Nottinghamshire CCG. Emma had consulted with NHS Nottingham CityCare Partnership Tissue Viability Team and Nottinghamshire Appliance Management Service.
Changes made as follows:

- Second-line cream changed from LBF® Barrier Cream to Zerolon Barrier Cream.
- First-line spray changed from Proshield® Foam & Spray Skin Cleanser to Medi Derma-Pro® Foam and Spray Incontinence Cleanser.
- First-line wipes changed from Medi Derma-S® Non-sting Barrier Film Wipes to Preventox Skin Protective Barrier Wipes.

AR commented that an overarching flammable message might be required due to the flammability of emollients.
LK asked whether Secondary Care TVNs had been consulted.

ACTION: LC to establish if Secondary Care had been included in the consultation. Once clarified, final version to be uploaded to the APC website

<u>Opioids for non-cancer pain</u>

Michalina Ogejo (MO) presented an update of the Opioids for non-cancer pain guideline. This review was completed in collaboration with Roger Knaggs, Specialist Pharmacist in Pain management, PICS.
Minor wording changes had been made to help non-medical prescribers in an easier identification of patients that need regular opioid monitoring.
Change from *always prescribe* to *recommend* gives an opportunity to recommend laxatives suitable for OTC purchase (docusate and bisacodyl).

TH commented that if Opiodur was added they would like to be consulted as for Secondary Care it was a less cost-effective brand but acknowledged this would be looked as for the ICS as a whole.
AP asked if links to the opioid dose conversion charts could be added. MO explained as a team they had been recommending the ANZKA link, this link will be added to the document
MO asked if an over-arching pain guideline would be useful. The GP's felt a pain guideline would be a good idea and would be found useful.

ACTION: MO to review the cost impact of Opiodur to the health community. LC to upload the final document. MO to develop an over-arching pain guide and bring to a future meeting.

<u>Clozapine information sheet and blood monitoring levels</u>

This information sheet has been kept separate from the antipsychotic prescribing guideline due to the volume of information it includes. The main change is a new section on blood level monitoring which incorporates the August 2020 MHRA guidance along with advice on when/how to take clozapine blood levels in primary care. This information has already been included in the June 2021 Prescribing Hints and Tips Newsletter.

AP raised smoking cessation in relation to clozapine. The smoking cessation service is due to expand in size imminently and likely to come across more patients on clozapine. AP asked how the mental health specialists would want the service to manage these patients. HG explained that the relevant mental health team needs to be aware of clozapine patients who are considering stopping smoking before an intervention is made. ME confirmed that a baseline assessment of clozapine blood levels, dose and side effects is required by the mental health team. ME also highlighted that severe mental illness (SMI) patients are generally more resistant to population approaches to smoking cessation and still smoke at pre-intervention rates; anything we can do to support and encourage cessation in this patient cohort is positive.

LC queried whether more information needs to be cascaded to primary care about clozapine and smoking.

ME further mentioned changes to smoking habits can also have an effect on Olanzapine and Lithium levels.

AA queried whether templates for mental health physical health checks in primary care need to be amended to highlight the clozapine and smoking interaction. Anna Davis offered to review and update the F12 template. LC highlighted that Mid Notts use Ardens – Anna will find out who updates Ardens and liaise with them.

ACTION: HG to amend the smoking cessation section on the information sheet to further highlight the need for communication with the mental health team before an intervention is made. HG to upload.
HG to write a segment on clozapine/olanzapine and smoking for the next Prescribing Hints and Tips Newsletter
Anna Davis to update the mental health physical health check template on F12 and liaise with the person who updates the Ardens template.

Antimicrobial guideline – Eczema

SW introduced an update to the Eczema antimicrobial guideline based upon the March 2021, NG190: Secondary Bacterial Infection of Eczema. Nicola Butcher MO Pharmacist, Nottingham and Nottinghamshire CCG had completed a review of the update in consultation with Dr Vivian Weston, NUH consultant Microbiology and Infection Control, NUH Trust.
The update aimed to optimise antibiotic use and reduce antibiotic resistance. The recommendations are for adults, young people and children aged 72 hours and over. The guidelines do not cover diagnosis.
AR had asked about escalation and if swabbing for infection was required. SW explained that routine skin swab for microbiological testing at initial presentation is not recommended by NICE as eczema is often colonised with bacteria but not necessarily be clinically infected. Additionally, patients should be referred to the hospital if there are red flags such as symptoms of sepsis, and symptoms that are rapidly or significantly worsening at any one time.

ACTION: SW to upload to the APC website

Freestyle Libre inclusion criteria

LC introduced the updated Freestyle Libre prescribing criteria. Libre 2 sensors are now available and these incorporate a warning system for hypoglycaemia and a reduced lag time between reading and plasma glucose. Hence, there is no longer a need to routinely check capillary glucose.

In consultation with Dr K.Chokkalingam and Dr Kerri Sallis an updated inclusion criterion has been developed. The specialist professionals who can initiate the technology has also been updated on the latest version. LC presented some of the epact data for testing strips and gave an overview of the comments received related to the inclusion criterion. The update is in line with NHSE guidance. LC explained patients were being switching from Libre1 to Libre2 at their next diabetes review.

ACTION: LC to upload to the APC website and remove the restriction for consultant initiation only.

Blood glucose test strip choice

LK informed the APC about a request to sanction the use of Freestyle Optium Test strips for patients that are using the Freestyle Libre system.

Currently, the CCG has a formulary for Blood Glucose Test Meters that includes cost effective choices and Freestyle Optium is not listed. Many patients that are eligible for the Freestyle Libre system are exempt from the formulary but discussions had taken place with paediatric diabetes clinicians in order to ascertain whether a more cost-effective alternative could be utilised, rather than the premium Freestyle Optium Test strips. For patients using the Libre reader for scanning rather than a mobile phone, using the Optium strips prevents the need for a second meter and this is seen as highly desirable by the specialist team. All paediatric patients are advised to use the reader, but many adult patients use a mobile phone. As this is the current practice, no cost implication is expected, but the Optium strips are approximately £8 more a box than the more cost-effective choices listed on the formulary.

The APC agreed that continued use was appropriate for this patient group, but requested that it is highlighted that strips are only ordered when needed, rather than automatically on every repeat prescription request. It was suggested that this should be added into the Freestyle Libre patient contract.

Actions: LK to update the formulary. LC to update Freestyle Libre contract with regards to ordering of test strips

SNRIs and BP monitoring statement

HG presented the monitoring statement and the reasoning behind its production.
The Nottinghamshire APC Venlafaxine Higher Dose Information Sheet was retired in May 2021. This contained some important information about blood pressure monitoring which actually applies to SNRIs (Venlafaxine and Duloxetine) at any dose.
This consensus statement has been formulated to highlight best practice in regards to BP monitoring with these medicines. The information has been adapted from the Summary of Product Characteristics to provide practical advice to clinicians.
The plan is to include this information on the Nottinghamshire Joint Formulary – linked to the individual SNRI entries, not introduce as a separate guideline/information sheet.

ACTION: HG to update the formulary entries for Venlafaxine and Duloxetine

Prucalopride prescribing information sheet

LC presented the information sheet which had been produced in consultation with Christine Morgan Continence Nurse Advisor, Nottinghamshire Healthcare NHS Foundation Trust.
NICE states:
Prucalopride should only be prescribed by a clinician with experience in treating chronic constipation, who has carefully reviewed the woman's previous courses of laxative treatments.

Historically the formulary entry was restricted to gastroenterology consultants only. The specialist continence nurses at the continence service are aiming to develop a whole bowel pathway to negate the need for hospital referrals and to allow the management of patients within primary care. Part of the pathway includes the use of prucalopride which currently is restricted to consultant initiation only.

It is not anticipated that prescribing volume would increase significantly, however referral to secondary care is expected to be reduced.

The prescribing information sheet aims to give support to GPs in ensuring a patient is appropriately

initiated on prucalopride as well as outlining responsibilities and on-going management.

Prucalopride is licensed for both men and women and is included on the joint formulary as such. The request is for Amber 2 - specialist recommendation with GPs asked to prescribe with review after a month's supply by the continence advisors.

LC will look at the activity levels and discuss the cohort of patients on the pathway with the continence advisors. Prucalopride will also be added to the action log for ePACT data prescribing review in 6 months in order to monitor usage.

ACTION: Add as Amber 2 specialist recommendation, GPs to prescribe for one month then reviewed by the continence advisors. LC to review prescribing data in 6 months and review onging restrictions.

Initiation of Gastroprotection in patients prescribed Antithrombotic Agents Quick Reference Guide

LC presented the quick reference guide on behalf of NUH which had been put forward for hosting on the APC website. The guide had been approved by NUH and comments have been made by MSO groups and fed back to the authors.
If hosted on the APC website it was felt it needed to be branded as APC and the authors acknowledged. LC to gain confirmation that SFHT cardiologists have been consulted and confirm the recommended PPI dosage.

ACTION: Following the checks mentioned it was agreed the quick reference guide could be upload by LC

Formulary amendments

All formulary amendments were agreed as per the Joint Formulary recommendations on the 20th May 21, with the exception of the following which was discussed in more detail:

Currently, the SGLT2 inhibitors (Canagliflozin, dapagliflozin, empagliflozin, ertugliflozin) are classified as Amber 3. The diabetes team put forward a request to reclassify these to green in order to increase their usage.It was felt that the current classification is preventing GPs from initiating SGLT2 inhibitors, despite the guideline allowing this. The Amber classification could be a barrier for some and many other areas classify these medications as green. The JFG felt that more education around the traffic light classification was required within Primary Care rather than the re-classification of medications and was minded to keep the Amber 3 classification for SGLT2 inhibitors. In addition, they also recommended the reclassification of gliclazide and pioglitazone from Green to Amber 3 in line with other 2nd line medications for T2DM. Metformin reclassification was considered but it was felt that green was appropriate for first-line use.
APC was in agreement with this.

ACTION: LC to promote the meaning of the Amber 3 classification via the bulletin. KR to update the formulary

Horizon scanning

All the horizon scanning entries were noted as per the Joint Formulary recommendations on the 20th May 21, with the exception of the following which was discussed in more detail:

Mesalazine 1G (Octasa® 1G Suppositories) – Provides a more cost-effective option to Pentasa suppositories. LK had discussed this with the gastroenterologists and they were happy with this as a more cost-effective alternative. Discussions were continuing about the suitability of switching patients however for new patients Octasa would be the first-line option.

ACTION: KR to update the formulary

New applications

a) Bempedoic Acid – NICE TA 694

NICE published this TA on the 28th April 2021 requiring implementation by 27th July 2021. Bempedoic acid with ezetimibe is recommended as an option for treating Primary Hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. JFG had discussed this and recommended an Amber 2 classification for both products in line with the NICE TA, but with encouragement to prescribe the more cost-effective combination product. The NICE TA references a commercial arrangement, but this will be received centrally as a reimbursement directly to NHS England. The NHS list price should therefore be used for any local costing work. TB has added a slight amendment to the hyperlipidaemia guideline, the group were happy for this change to be ratified by email.

ACTION: LK to add to the formulary as Amber 2, TB to email the hyperlipidaemia guideline to members for ratification

b) Nutrizym®22

An Amber 2 classification was requested by NUH for the indication of pancreatic exocrine insufficiency in patients experiencing an allergic reaction or intolerance symptoms with Creon®.

Nutrizym®22 is currently non-formulary but it is the cheapest and closest alternative to Creon® 25,000. SFHT gastro consultants had been consulted and they were in agreement with the formulary addition.
APC agreed on an Amber 2 classification, for second-line use after Creon® for patients intolerant of Creon®

ACTION: SW in inform submitter and update the formulary

c) Agomelatine

SW presented the agomelatine submission to the group and provided feedback on the JFG discussion with Dr Nixon. A formulary reclassification for agomelatine had been submitted by Nottinghamshire Healthcare NHS Trust, requesting an Amber 2 classification as a fourth-line option for the treatment of major depression in adults where other antidepressants have proven ineffective or poorly tolerated. JFG recommended Amber 2 classification pending further primary care input at APC before making a decision.

ME explained that in Nottinghamshire we have the specialist depression service which is essentially a tertiary service. Therefore this is why we have a different formulary position on some antidepressants compared to surrounding counties.

JML asked about when it's clinically appropriate to do LFT monitoring after the initial 24 week period. ME confirmed that he would only repeat after this point if there was clinical suspicion of a liver problem.

In Nottinghamshire's tertiary service there are currently only 13-14 patients and greater numbers were not anticipated. ME felt keeping prescribing within secondary care for the first three months, whilst LFT monitoring is more intensive, is appropriate. The 24th week (6 month) LFT monitoring could be done in primary care; the committee was in agreement with this.

TB highlighted the concern from JFG about increases in prescribing following an Amber 2 reclassification. Also queried about the impact of a tertiary service prescribing for out of area patients where the traffic light classification for agomelatine could be different. ME didn't feel this would be a big problem due to low levels of agomelatine prescribing.

JML queried whether these patients would be on the SMI register and would therefore qualify for annual physical health checks. ME thought this was likely and acknowledged these patients would therefore have annual LFTs.

AA asked how discontinuation would occur, ME and HG felt it should be gradual as per other long term antidepressants due to lack of specific data. AA wondered whether the sleep effect of agomelatine would make discontinuation more difficult. This may become clearer over time when there is more clinical experience of using agomelatine.

DK queried about re-starting the LFT monitoring schedule if the dose is increased and whether this responsibility would fall to primary care. HG confirmed that dose amendments would only be made in secondary care and therefore the responsibility of re-starting the LFT monitoring schedule would remain with the specialist. JML highlighted the need for effective communication in instances where doses are increased further down the line when prescribing has already been transferred to primary care.

The committee felt that an APC prescribing information sheet is required. HG will bring this to the next APC meeting for ratification. APC agreed Amber 2.

ACTION: HG to produce an information sheet for the next meeting, HG to inform the submitter and update the formulary.

<u>AOB</u>

RMOC update.
TB informed the group that the Midlands and East RMOC met 15.6.21 for the first time since Dec 19.
RMOC has new terms of reference and will split into 2 groups Midlands RMOC and East RMOC.
Refresher of areas of work for the committee - will become more focussed to local views eg better alignment /linking with APCs.
Midlands RMOC still lead for AMR and expect there to be an AMR subgroup that reports to it.
Documents for discussion – one on shared decision making re religious, cultural or ethical considerations on choice of medicine and one on a commissioning framework for pitolisant.
Comments were made on both, final documents not yet available.

Rapid tranquilisation guideline
HG highlighted that a request has been received from Andrew Wignall at NUH for the NHCT rapid tranquillisation guideline to be added to the joint formulary. There was a link previously but that link

is now broken. HG felt there would be a governance issue with sharing this guidance as it's specifically written for NHCT staff who undergo regular rapid tranquillisation training. Also, NUH has its own separate rapid tranquillisation guidance for adults which differs from the NHCT version in some respects.

SM felt that it would be good to have the link there but if other organisations wished to formally adopt it then they would need to take it through their respective DTC. The committee agreed that if the guidelines were available on the formulary then it would be the responsibility of any other organisation(s) using them to have governance processes in place to ensure that the guidelines are used (or not used) appropriately.

ACTION: HG to discuss further with TH and LK outside of the APC meeting.

Lung Health meeting.

Lung check programme early intervention programme will be trialling the use of e-cigarettes. These will not be prescribed and GPs should not be asked to supply. ME will contact TB to discuss this further with regard to mental health patients

Hydroxychloroquine ophthalmological monitoring

LK had updated the hydroxychloroquine SCPs so that they reflected the updated advice from the Royal College of Ophthalmologists. It had been highlighted that there were some commissioning and capacity issues at NUH, but it was felt that the APC's documents should be updated so that they are in line with the current advice whilst the commissioning work is ongoing.

Breastfeeding booklet

JML informed the group about Breastfeeding guidance that included prescribing information. This will come to APC for hosting if agreed

Date of next meeting – 19th August 2021

The meeting finished at 16:50